MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

08223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 10 months 29 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2015 East Chase Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ALMA LOUISE ALEXANDER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col	Married

6.(b) Name of husband or wife: Collins Alexander

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): April 8, 1919

8. AGE: Years	Months	Days	If less than one day
29	4	16	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Lorenzo Jones

13. Birthplace: N. Carolina

MOTHER — 14. Maiden name: Alverta Jones

15. Birthplace: Baltimore, Maryland

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-27-48 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Baltimore

18. Funeral director: Chas G. Cooper

Address: 512 N Carrollton ave

19. August 24 1948 (Date rec'd by registrar) Albert R. Swanborg Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1948 at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26 1945 to August 24 1948 and that I last saw her alive on August 24 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	July 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 8/24/48

RECEIVED
AUG 25 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08230

13 a

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 88 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary E Algire

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of ~~husband~~ wife: Melchoir Algire

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 22 - 1859

8. AGE:

Years	Months	Days	If less than one day
88	10	20	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Charles Richards

13. Birthplace: Maryland

MOTHER

14. Maiden name: Rezilah Poole

15. Birthplace: Maryland

16. Informant: Mrs Roland Brooks

Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 14/48 (month) (day) (year)

Cemetery or crematory: Hampstead

Location: Carroll Co. Md

18. Funeral director: Edes & Tipton

Address: Hampstead Md

19. Aug. 13 1948 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 12 1948, at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1948, to Aug. 12 1948

and that I last saw her alive on Aug. 11 1948

Immediate cause of death	DURATION
Uremia	1 week -
Due to: Arterio sclerotic C-V Renal disease	8 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Maurice C. Pumphrey M. D. or other

Address: Hampstead, Md Date signed: 8-12-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully, giving the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
AUG 16 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

pre 13-b

08231

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-5-

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1640 Miller Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN ASKINS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 16, 1877

8. AGE: Years	Months	Days	If less than one day
71	0	15	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 9-4-1948

Cemetery or crematory: Mt Calvary

Location: A. A. County

18. Funeral director: Mrs Robert E Hintz + daughter

Address: 1129 N. Caroline St.

19. August 31 1948 (Date rec'd by registrar) Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1948, at 7.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 23 1948, to August 31 1948, and that I last saw him alive on August 31 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Steman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 8/31/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 3 1948
BUREAU

08232

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville da.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs 6 mo 13 ddd

Hospital, institution, or street address where death occurred: Springfield State Hospital da.

How long in hospital or institution? 20 yrs 6 mo 13 ddd

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2152 W Hollins St.

(If rural, give LOCATION)

2152 Hollins St.

2.(a) If veteran, name war:

3.(a) FULL NAME Sophia J Baader

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

8.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Mar 7th - 1906

8. AGE:

Years	Months	Days	If less than one day
42	5	15	hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER 12. Name	Rudolph Baader
13. Birthplace	Germany
MOTHER 14. Maiden name	Lena Hirsch
15. Birthplace	Germany

16. Informant: Henry Baader Address: 2152 W Hollins St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-25-48 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore Md.

18. Funeral director: George L. Schwab

Address: 2401 Frederick Ave.

19. 8/23 1948 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 1948 at 12-05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9th 1928 to Aug 22 1948 and that I last saw her alive on Aug 22 1948

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs
Due to	
Epilepsy	34 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Masters M.D. M.D. or other

Address: Sykesville Md. Date signed 8/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08233

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or Institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore-17-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1836 Presstman Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME: EMILY OLIVIA BARKLEY

3. (b) Social Security Number: 214-20- 1699

4. Sex: female
5. Color or race: Col/.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Raymond Barkley
6.(c) If alive, give age: 61 years
7. Birth date of deceased (mo., day, yr.): February 21, 1894
8. AGE: Years 54 | Months 5 | Days 28 | If less than one day ... hrs. ... min.
9. Birthplace: Marion, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Samuel Holland
13. Birthplace: Maryland
MOTHER 14. Maiden name: Rosa White
15. Birthplace: Maryland
16. Informant: Daughter-Mrs. Rosa Harcum
Address: 1822 Walbrook Ave. Baltimore-17-Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 22 1948 (month) (day) (year)
Cemetery or crematory: Dames Quarter, Md.
Location: Eastern Shore, Md.
18. Funeral director: Edwin C. Wilson
Address: 1000 Brantley Ave.
19. August 18 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1948, at 2:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2, 1948, to August 18 1948 and that I last saw her alive on August 18 1948.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	November 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Reuben W. Truman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 8/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
AUG 20 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08234

107

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Few minutes

Hospital, institution, or street address where death occurred: 109 E. Main St.

How long in hospital or institution? Few Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Rural - Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 6

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Martha Jane Beaver.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5 - 1948

8. AGE:

Years	Months	Days	If less than one day
	1	11	hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Infant.

11. Industry or business:

FATHER 12. Name: Ralph E. Beaver

13. Birthplace: Maryland

MOTHER 14. Maiden name: Laura Virginia Mueller.

15. Birthplace: Md

16. Informant: Ralph E. Beaver

Address: Westminster Md Route 6

17. Burial (Burial, cremation, or removal. Which?) Data thereof 8-18-48 (month) (day) (year)

Cemetery or crematory: Salem

Location: Salem, Carroll Co. Md.

18. Funeral director: C.M. Waltz

Address: Wightield. Md

19. 8/17/48 (Date rec'd by registrar) 19.. H. E. Almond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19.. to ... 19..

and that I last saw h... alive on ... 19..

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: Malnutrition	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work? ...

23. SIGNATURE James T. Mond Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed 8-16-48

RECEIVED
AUG 18 1948
BUREAU V. S.

08825

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 83

1. PLACE OF DEATH:
County: Carroll
City or town: Woodbine Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Woodbine (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Persis Beckley.

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: John H Beckley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 17-1867

8. AGE: Years 81 | Months 7 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Joshua Tracy
13. Birthplace: Md

MOTHER
14. Maiden name: Jane Wheeler
15. Birthplace: Md

16. Informant: J. J. Henby
Address: Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug 21/48 (month) (day) (year)
Cemetery or crematory: Beckleyville
Location: Baltimore Md

18. Funeral director: Edw C Tipton
Address: Hampstead Md

19. Aug 24 1948 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1948 at 11A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to death 1948
and that I last saw h— alive on 1948

Immediate cause of death: senility
hypertensive cardiovascular disease — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: S. H. Lawson M. D. or other
Address: Sykesville Date signed: 8/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
NOV 24 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08235

93d

Reg. Diat. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, Institution, or street address where death occurred: York Street Ext.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mary Land County: Carroll
City or town: Manchester Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: York St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Emma Catherine Berwager

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Berwager
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 15, 1862

8. AGE:

Years	Months	Days	If less than one day
86	1	8	... hrs. ... min.

9. Birthplace: Manchester Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER
12. Name: Jacob Wagner
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Sherman
15. Birthplace: Maryland

16. Informant: Minnie Wentz
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-29-48 (month) (day) (year)
Cemetery or crematory: Reformed
Location: Manchester Md

18. Funeral director: Jacob Weiks Sons
Address: Manchester Md.

19. Aug 29th 1948 (Date rec'd by registrar) Mrs. W. P. S. Danner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1948 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24 1948, to Aug 26 1948
and that I last saw her alive on August 24 1948

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to: Arterio-Sclerotic Cardio Vascular Disease	-
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Buck M.D.
M. D. or other
Address: Hampstead Md Date signed 8/26/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 31 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08236

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Gamber
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 11 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Gamber Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: RD Finksburg
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John H. Boone

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife: Susan Boone deceased 6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 13, 1860

8. AGE:

Years	Months	Days	If less than one day
88	5	26	hrs. min.

9. Birthplace: Ducktown, Tenn.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: John S. Boone
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ann Turnbill
15. Birthplace: North Carolina

16. Informant: Miss Ruby Boone
Address: Finksburg. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-12-48 (month) (day) (year)
Cemetery or crematory: Mt. Pleasant
Location: Gamber, Carroll Co. Md.

18. Funeral director: C. M. Walsh
Address: Winfield. Md.

19. AUG 10 1948 (Date rec'd by registrar) Registrar: Ray Engle Dep Reg

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1948, at 6.30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8th 1948, to August 9 1948.
and that I last saw him alive on August 8th 1948.

	DURATION
Immediate cause of death: acute Cardiac Decompensation	10 hrs.
Due to: acute Interstitial Nephritis.	3 days.
Due to: arteriosclerosis	10 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. R Fouty M.D. M. D. or other
Address: Westminster, Md. Date signed 8.10.48

RECEIVED
AUG 13 1948
BUREAU V. S.

08237

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and complete. Age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sams Creek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residance of mother)

State: Maryland County: Carroll

City or town: Sams Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Fannie Isabelle Borland

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~: William T Borland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 28- 1863

8. AGE:

Years	Months	Days	If less than one day
84	10	19	..... hrs. ..... min.

9. Birthplace: Frederick County (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: Martin Devilbiss

13. Birthplace: Maryland

MOTHER

14. Maiden name: Martha Stocksdale

15. Birthplace: Maryland

16. Informant: William T Borland

Address: New Windsor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 19- 1948 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Sams Creek

18. Funeral director: D D Hartzler & Sons

Address: New Windsor & Union Bridge, Md

19. Aug 17 1948 (Date rec'd by registrar) Evo B Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 19 48 at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1. 19 48. to Aug 16 19 48

and that I last saw her alive on Aug 14 19 48

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Arteriasclerotic cardio-vascular Disease.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Merritt E Robertson M D (M. D. or other)

Address: New Windsor, Md Date signed: Aug 17, 1948.

RECEIVED
AUG 19 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 132 08238

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2000 Victor St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Chester Bargan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1911

8. AGE: Years: 37 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Kansas (Town, county, and state)

10. Usual occupation: Seaman

11. Industry or business:

FATHER — 12. Name: Charles W. Bargan

13. Birthplace: Kentucky

MOTHER — 14. Maiden name: Myrtle Hadney

15. Birthplace: Ohio

16. Informant: Hospital records

Address: Sykesville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 8-30-48 (month) (day) (year)

Cemetery or crematory:

Location: Wichita, Kansas

18. Funeral director: Wm. Cook Inc.

Address: 1717 N Paul St. Balto. Md.

19. Aug. 29 1948 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 28, 1948 at 11:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 26, 1948 to Aug. 28, 1948 and that I last saw him alive on Aug. 28, 1948

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to: Nephritis	
Due to:	
Other conditions: Psychosis with chronic alcoholism delirium tremens (Include pregnancy within 3 months of death)	?

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall M.D. M. D. or other

Address: Springfield State Hospital Date signed: 8/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 31 1948
BUREAU V. S.

Evidence for change of birth date and age shown on:

FILM No. G.117 AUG 27 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

0823

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 11 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 5 years, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: — — —

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. — — —

(If rural, give LOCATION)

2.(a) If veteran, name war — — —

3.(a) FULL NAME

BUTLER, George M.

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife — — —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) January 18, ~~1873~~ 1871

8. AGE:

Years	Months	Days	If less than one day
77 ~~74~~	6	28	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Sexton

11. Industry or business — — —

FATHER

12. Name: Martin S. Butler

13. Birthplace: Baltimore, Maryland

MOTHER

14. Maiden name: Frances Ford

15. Birthplace: Baltimore County, Md.

16. Informant: Records of the Springfield St. Hospt.

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/18/48 (month) (day) (year)

Cemetery or crematory: Loudon Pk.

Location: Frederick Rd.

18. Funeral director: Clarence F. Hoffmann

Address: 1639 Broadway.

19. 8/17/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1948, at 5:00 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 1 1947, to August 15 1948 and that I last saw him alive on August 15 1948

Immediate cause of death	DURATION
Arteriosclerosis	more than 5 yrs
Due to	
Due to	
Other conditions: Senile psychosis	more than 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations — — —

Date of op. — — —

Autopsy results — — —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — — — Date of — — —

Where did injury occur? — — — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) — — —

Means of injury — — — Injured at work? — — —

23. SIGNATURE: Martin Gross, M.D.

Martin Gross, M.D. M. D. or other

Address: Sykesville, Maryland Date signed 8/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

08240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 3 mos 5 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 5 yrs 3 mos 5 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1801 E. Lafayette Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Bertha Carbaugh.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: [illegible]

6.(c) If alive, give age: 5 years

7. Birth date of deceased (mo., day, yr.): 11 - 11 - 1904

8. AGE: Years 43 | Months 9 | Days 20 | If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER

12. Name: William H. Clark

13. Birthplace: Md.

MOTHER

14. Maiden name: Mary Coleman

15. Birthplace: Md.

16. Informant: Mrs. Nellie Wagner

Address: 1801 E. Lafayette Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-3-48 (month) (day) (year)

Cemetery or crematory: London Park Cem.

Location: Balto. Md.

18. Funeral director: Williams Cook, Inc.

Address: 1217-19 Park St.

19. Aug. 31 1948 (Date rec'd by registrar) C. Henry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31st 1948, at 9-45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1943 to Aug 31st 1948 and that I last saw h[illegible] alive on Aug 31st 1948

Immediate cause of death	DURATION
Bronchopneumonia	3 da
Due to Huntington's Chorea	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. D. Gaston M.D. M.D. or other

Address: Sykesville Md. Date signed 9/1/48

RECEIVED
SEP 2 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

08241

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster (rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 4.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Henry Conant

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Katherine Gaines

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): December 7, 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	7	30		

9. Birthplace: Burlington, Vermont
(Town, county, and state)

10. Usual occupation: Shoe worker (retired)

11. Industry or business:

FATHER 12. Name: Henry Conant

13. Birthplace: Vermont

MOTHER 14. Maiden name: Frances Hovey

15. Birthplace: Vermont

16. Informant: Ralph Conant

Address: Westminster, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/7/48 (month) (day) (year)

Cemetery or crematory: Childs Cemetery

Location: Cornish Flat, N. H.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 8/6 (Date rec'd by registrar) 19 48 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1948, at 10¾a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about April 1st 1947, to Aug. 6th 1948 and that I last saw him alive on Aug. 6th 1948

Immediate cause of death	DURATION
Pernicious Anemia	abt 18 mo.
Due to —	
Due to —	
Other conditions Uremia & coronary arteritis (Include pregnancy within 3 months of death)	2 yrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. T. Billingslea, Md. M. D. or other

Address: Westminster, Md. Date signed: 8-6-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 9 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

08242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll Md

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 12.6.1929

Hospital, institution, or street address where death occurred:

Springfield St. Hosp.

How long in hospital or institution? 18 years 7 months 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: [redacted]

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1824 East Lombard St.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME Duffy Winifred.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Wh.	sgl.

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) - - 1886

8. AGE: Years	Months	Days	If less than one day
62			..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: -

FATHER

12. Name: Joseph H. Duffy

13. Birthplace: Maryland

MOTHER

14. Maiden name: Anna M. Theisen

15. Birthplace: Ohio

16. Informant: Brother: Peter V. Duffy

Address: 1824 East Lombard St. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-25-48 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cem.

Location: Balto. Md.

18. Funeral director: Lilly & Zeiler, Inc.

Address: 403 S. Wolfe St.

19. Aug. 22 1948 C. Harvey Ward

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21. 1948, at 12 midnight

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h[illegible]alive on Aug 21. at 9. P.M. 1948

Immediate cause of death	DURATION
Carcinomatosis	
Due to Carcinoma of the	
Due to Intern with metastases to the lungs	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Elizabeth V. Winans M.D.

M. D. or other

Address: Springfield St. H. Date signed Aug. 22. 48

RECEIVED
AUG 26 1948
BUREAU V. S.

08243

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83c

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 years

Hospital, institution, or street address where death occurred: 68 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 68 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Beulah Edna Erb

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	w.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 26, 1874

8. AGE: Years: 74 Months: 6 Days: 22 If less than one day: hrs. min.

9. Birthplace: Near West Minster Carroll Co. Md. (Town, county, and state)

10. Usual occupation: retired W.C.A. worker

11. Industry or business:

FATHER 12. Name: John Thomas Erb

13. Birthplace: Carroll Co. Md.

MOTHER 14. Maiden name: Beulah H. Slaugh

15. Birthplace: Carroll Co. Md.

16. Informant: Mrs. Lillian Byers

Address: 68 W. Main St. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 20. 48 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. E. Myers, Jr.

Address: Westminster, Md.

19. 8/18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1948, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1948, to Aug 17 1948

and that I last saw h[illegible] alive on August 14 1948

Immediate cause of death	DURATION
Cerebral softening	7 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. Reese Wilkens MD

M. D. or other

Address: Westminster Date signed: 8/18/48

RECEIVED
AUG 21 1943
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08244

510 ✓

Reg. Dist. No. 7X

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 515 Murdock Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
LEWIS BENJAMIN EYLER

3.(b) Social Security Number
?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Mary S. Eyler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 6, 1865

8. AGE: Years	Months	Days	If less than one day
83	7	8	..... hrs. ..... min.

9. Birthplace Frederick County, Maryland
(Town, county, and state)
10. Usual occupation Riveter
11. Industry or business Iron Foundry

FATHER
12. Name Benjamin Eyler
13. Birthplace Frederick County, Maryland

MOTHER
14. Maiden name Martha Rider
15. Birthplace Frederick County, Maryland

16. Informant Record, Springfield State Hospital
Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/16/48 (month) (day) (year)
Cemetery or ~~crematory~~ Woodlawn Cem.
Location Pikesville, Balto. Md.
18. Funeral director WM. J. TICKNER & SONS INC.
Address North & Pa. Aves. Balto. 17, Md.

19. 8/13 (Date rec'd by registrar) 1948 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

(DST)

20. DATE OF DEATH August 12 19 48 at 4:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 19 48 to August 12 19 48 and that I last saw h ... alive on August 12 19 48

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	5 years
Due to arteriosclerosis	10 years
Due to	
Other conditions Psychosis with cerebral arteriosclerosis and cancer of the male genito-urinary organs	6 months 5 months

(Individual process within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ike Mamm M. D. or other
Address Sykesville, Maryland Date signed 8/12/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08245

13 b

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 27 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 3
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Annanies Foreman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	Married

6.(b) Name of husband or wife: Elsie Foreman

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): March 22, 1896

8. AGE: Years	Months	Days	If less than one day
52	4	15	..... hrs. ..... min.

9. Birthplace: New Jersey
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Samuel Foreman
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Selby
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. State Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 9th 1948 (month) (day) (year)

Cemetery or crematory: State

Location: Berlin Md

18. Funeral director: James W. Stewart

Address: Salisbury Md

19. August 6, 1948 (Date rec'd by registrar) Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6, 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 1947, to August 6, 1948 and that I last saw her alive on August 6, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Rabun D. Bowman, M. D. (M. D. or other)

Address: Henryton, Maryland Date signed 8-6-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 10 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

08246

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 11 mos. 2 da

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 5 yrs. 11 mos. 2 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3420 Gwynn Oak Pkwy.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Hallie Gaddess

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife: Unk

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unk. 1875

8. AGE: Years: 73. Months: Days: If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housemaid

11. Industry or business: Home.

FATHER — 12. Name: Thomas Edes

13. Birthplace: Kent Co. Md.

MOTHER — 14. Maiden name: Sarah Elizabeth Parker

15. Birthplace: Kent Co.

16. Informant: Alex Gaddess

Address: 445 Van Pelt St. Philadelphia

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5 1948 (month) (day) (year)

Cemetery or crematory: Springfield

Location: Sykesville Md

18. Funeral director: A Harry Kerr

Address: Sykesville Md.

19. Aug 4 1948 (Date rec'd by registrar) A Harry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 3 1948 at 6-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1942 to Aug. 3 1948 and that I last saw her alive on Aug. 3 1948

Immediate cause of death	DURATION
Carcinoma of Stomach	6 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H Gaston M.D. M. D. or other

Address: Sykesville md Date signed: 8/3/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
AUG 6 1948
BUREAU V. S.

08247

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Freedom
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Freedom
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Harry C. Gist

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Katie S. Gist
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): June 28, 1882

8. AGE:

Years	Months	Days	If less than one day
66	1	22	...hrs. ...min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: William B. Gist
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice V. Grimes
15. Birthplace: Maryland

16. Informant: Mrs. Katie S. Gist
Address: Sykesville, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: 8-23-48 (month) (day) (year)
Cemetery ~~or crematory~~: Freedom
Location: Freedom, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Aug. 21 1948 (Date rec'd by registrar) C. Harry Weaver Registrar

MEDICAL CERTIFICATION Prov D

20. DATE OF DEATH: Aug 20 1948, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Cardiac decompensation	
Due to: Chronic Myocarditis	2-3 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None ... Date of op. ...
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work? ...

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other
Address: Westminster Md. Date signed 8/20/48

RECEIVED
AUG 26 1948
BUREAU F. S.

08248

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

119a

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos 1 yr dec

Hospital, Institution, or street address where death occurred:
N. Center St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. N. Center St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ronald Lee Gist

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	—

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 3 — 1948

8. AGE: Years —; Months 6; Days 21; If less than one day ____ hrs. ____ min.

9. Birthplace Hanover Hospt. Hanover, Pa.
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER
12. Name Francis Levine Gist
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Mary Mantaumm
15. Birthplace Carroll Co. Md.

16. Informant Francis L. Gist
Address N. Center St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 26 - 1948 (month) (day) (year)

Cemetery or crematory Deerhark Cemetery

Location Smallwood, Md.

18. Funeral director H B Bankard Son

Address Westminster, Md.

19. 8 25 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1948, to August 24 1948 and that I last saw him alive on August 24 — 1948

	DURATION
Immediate cause of death cholera infantum	2 days
Due to Colitis acute	4 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Chas. R. Fouty, M.D.
M. D. or other

Address Westminster Md. Date signed 8-25-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
AUG 27 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08249

932d

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

R.D. # 2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. 6.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Kinsey Eugene Green

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife M. Margaret Klee

6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1865

8. AGE:

Years	Months	Days	If less than one day
83	6	26	..... hrs. ..... min.

9. Birthplace Carroll (Town, county, and state)

10. Usual occupation Farmer. Ret.

11. Industry or business

FATHER

12. Name John C. Green

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Mary Evans

15. Birthplace Carroll Co. Md.

16. Informant Herman F. Green

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 12, 1948 (month) (day) (year)

Cemetery or crematory Westminster Cem.

Location Westminster, Md.

18. Funeral director H. Bankard Son

Address Westminster Md

19. Aug 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 1948 to August 10 1948

and that I last saw him alive on August 9 1948

Immediate cause of death Cerebral Hemorrhage — DURATION: Aug 5/48

Due to Arterio Sclerosis — DURATION: several yrs

Due to Chronic Nephritis — DURATION: several yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster, Md. Date signed 8/11/48

RECEIVED
AUG 13 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 BC

08250

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1830 Pennsylvania Ave. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Edward Gross

3. (b) Social Security Number: 212-16-4590

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25, 1909

8. AGE: Years	Months	Days	If less than one day
39	2	14	hrs. min.

9. Birthplace: Prince George's County, Md. (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business:
FATHER 12. Name: William Gross
13. Birthplace: Unknown
MOTHER 14. Maiden name: Millie Unknown
15. Birthplace: Unknown
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/11/48 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore City
18. Funeral director: Geo. E. Kelson
Address: 1303 Presstman St.
19. August 8 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1948 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6 1948 to August 8 1948 and that I last saw him alive on August 8 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	June 1947.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Fraser, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 8/8/48

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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RECEIVED
AUG 10 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

307

08251

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural — Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs., 7 mos., 26 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 11 yrs., 7 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Frederick

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 602 E. Patrick St.
(If rural, give LOCATION)

2.(a) If veteran, name war: "

3. (a) FULL NAME: Charles A. Grove, Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 25, 1920

8. AGE:

Years	Months	Days	If less than one day
28	3	4	..... hrs. ..... min.

9. Birthplace: Frederick, Frederick Co., Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Charles A. Grove Sr.
13. Birthplace: Frederick County, Md.

MOTHER
14. Maiden name: Louise Morrison
15. Birthplace: Frederick, Md.

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1948 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Frederick, Md.

18. Funeral director: M. R. Etchison & Son
Address: Frederick Md.

19. Aug 29 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1948, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 3, 1939 to Aug. 29, 1948 and that I last saw him alive on Aug. 29, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	21 mos.
Due to:	
Due to:	
Other conditions: Congenital syphilis	Life
Juvenile paresis	14 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Springfield State Hospital Date signed 8/29/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 31 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08252

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll County.
City or town: Manchester Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months.
Hospital, Institution, or street address where death occurred:
Long View Nursing Home
How long in hospital or institution? 2 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: York
City or town: Hanover Penna
(If outside city or town limits, write RURAL and give nearest town)
Street No. 217 Ruth ave
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Edward M Grumbine.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Emma H Heckathorne (Deceased)
6.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): April 21, 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75	3	12		

9. Birthplace: York County
(Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: W. H. Grumbine
13. Birthplace: York County

MOTHER
14. Maiden name: Rose S. Sunseth
15. Birthplace: York County

16. Informant: W. E. Grumbine
Address: Hanover, Pa. R.D. # 4

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8-4-48 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Hanover Pa. Mt. Olivet
18. Funeral director: Jacob Whitaker Sons
Address: Manchester Md.
19. Aug. 2 1948 (Date rec'd by registrar) Mrs. W. P. Sommer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1948 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1948, to August 2 1948
and that I last saw him alive on August 2. 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 hrs.
Due to: Hypertension - Selerotic Cardio-Vascular Disease	
Due to:	
Other conditions: Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: Frank E. Bush M.D. M. D. or other
Address: Hanover Md. Date signed 8-2-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 5 1948
BUREAU V. S.

08253

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months 30 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore-5-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1645 Abbott Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Corene Hamlin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fema le	col	Married

6.(b) Name of husband or wife Mell Temple Hamlin
6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) October 22, 1915

8. AGE: Years	Months	Days	If less than one day
32	9	21	....hrs. ....min.

9. Birthplace Prince Edward's County, Virginia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Dennis Rowe
13. Birthplace Rice, Virginia
MOTHER 14. Maiden name Lorene Wiley
15. Birthplace Rice, Virginia
16. Informant Deceased
Address
17. Burial, Removal. (Burial, cremation, or removal. Which?) Date thereof Aug 16 48 (month) (day) (year)
Cemetery or crematory Farnwell Fla
Location Rayner Sanders
18. Funeral director 1412 Preston Street
Address
19. August 12 19 48 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 48 at 10:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13 19 47 to August 12 19 48 and that I last saw her alive on August 12 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 19 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben D. Swan, M.D.
M. D. or other
Address Henryton, Maryland Date signed 8/12/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
AUG 14 1948
BUREAU V. S.

08254

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

87c

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 109 E. Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Martha Hamon

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Dexter Hamon
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 29, 1875

8. AGE: Years	Months	Days	If less than one day
73	6	21	hrs. min.

9. Birthplace: Georgetown, Kentucky
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: James Dickson
13. Birthplace: Kenturcky

MOTHER
14. Maiden name: Nancy M. Level
15. Birthplace: Kentucky

16. Informant: Mrs. K. R. Hollinger
Address: Westminster, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/20/48 (month) (day) (year)
Cemetery or crematory: Lewisville Cemetery
Location: Lewisville, Indiana

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 8/19 (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 19 48 at 5:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 47 to August 19 48
and that I last saw her alive on August 16 19 48

Immediate cause of death	DURATION
Parkinsons Disease	4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J Reese Wilkens M. D. or Other
Address: Westminster Date signed: 8/19/48

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

RECEIVED
AUG 21 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08253

Reg. Dist. No. 7 4

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore -2
(If outside city or town limits, write RURAL and give nearest town)
Street No. 21 N. Central Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Ellsworth Harts

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	Married

6.(b) Name of husband or wife Lovely Harts
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) April 18, 1882

8. AGE: Years	Months	Days	If less than one day
66	4	0	hrs. min.

9. Birthplace Aberdeen, Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Sam Harts
13. Birthplace (unknown)

MOTHER
14. Maiden name Mary (unknown)
15. Birthplace Aberdeen, Maryland

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/21/1948 (month) (day) (year)
Cemetery or crematory Mt Calvery
Location A. A. County

18. Funeral director Mrs Robert Elliott + daughter
Address 112 E n. Caroline St.

19. August 18, 1948 (Date rec'd by registrar) Albert R. Trunkhouse Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18. 1948 at 6:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15, 1947, to August 18, 1948
and that I last saw him alive on August 18, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Fuman, M. D. M. D. or other
Address Henryton, maryland Date signed 8-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 20 1948
BUREAU V. S.

ITEM 6 b: letter from Dr. Hoffman changing wife's name on this cer.; filmed 9-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G117 LL 08256

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore-17-
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1228 McCulloh Street
(If rural, give LOCATION) ✓
2.(a) If veteran, name war:

3.(a) FULL NAME: SAMUEL FORREST HENDERSON

3.(b) Social Security Number: 212-10-0359

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Separated

6.(b) Name of husband or wife: ~~Myrtle~~ Henderson MEREDITH P. 6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): August 10, 1905

8. AGE:	Years	Months	Days	If less than one day
	43		17	....hrs. ....min.

9. Birthplace: Simpsonville, S.Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: George Henderson
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Ella Meekins
15. Birthplace: S.Carolina

16. Informant: Nephew- Mr. Harold Sullivan
Address: 1927 W. Lafayette Ave. Baltimore-17-Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 29, 1948 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location: Baltimore Co. Md.
18. Funeral director: Mr. George A. Hollan
Address: 1631 Druid Hill Ave

19. August 27 48 (Date rec'd by registrar) Albert R. Shanklin Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 19 48 at 1:45A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25 19 48 to August 27 19 48 and that I last saw him alive on August 27 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1, 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan M.D. M. D. or other
Address: Henryton, Maryland Date signed: 8/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
SEP 1 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

08257

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 5-28-47

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? since 5-28-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ~~Maryland~~ Va. County: ~~Frederick~~

City or town: Frederick Prospect Park,
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ~~Odd Fellows Home~~ 150 1 Penna. Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ——— ✓

3.(a) FULL NAME: IGLEHART, Francis Henry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 2-19-70

8. AGE: Years	Months	Days	If less than one day
78	6	9	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Retired clerk

11. Industry or business:

FATHER — 12. Name: Francis Iglehart

13. Birthplace: Maryland

MOTHER — 14. Maiden name: ?

15. Birthplace: ?

16. Informant: Hospital records

Address: Springfield State Hospital

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: Aug. 29, 1948 (month) (day) (year)

Cemetery or crematory: .....

Location: Frederick, Md.

18. Funeral director: M. R. Ebbinson & Son

Address: Frederick, Md.

19. (Date rec'd by registrar) Aug 29 1948 — Harry Kerr, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 19 48 at 2.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 19 47 to Aug. 28 19 48 and that I last saw him alive on August 28 19 48

Immediate cause of death	DURATION
Chronic myocarditis and myocard. degeneration	more than 1 yr
Due to:	
Due to:	
Other conditions: Senile psychosis	about 2 yrs
Hip fracture, left (Include pregnancy within 3 months of death)	7 weeks

Major findings of operations: ——— Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident — Date of: 7/10/48

Where did injury occur? Sykesville (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?): Springfield State Hosp.

Means of injury: Fall ——— Injured at work? ——— (4/20/48-S)

23. SIGNATURE: Martin Gross, M.D. — Martin Gross, M.D.
M. D. or other

Address: Sykesville, Md. Date signed: 8-28-48

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 31 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

85 BC

08258

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs 2 mos 14 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 15 yrs 2 mos 14 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant, give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 804 N Gay St., (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lucy Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 14th - 1920

8. AGE:

Years	Months	Days	If less than one day
28	6	22	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER — 12. Name: George Johnson

FATHER — 13. Birthplace: Sylvania Ga.

MOTHER — 14. Maiden name:

MOTHER — 15. Birthplace: New Orleans

16. Informant: George Johnson

Address: 804 N Gay St Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 11, 1948 (month) (day) (year)

Cemetery or crematory: Springfield Hospital Cem.

Location: Sykesville, Md.

18. Funeral director: Harry Heer

Address: Sykesville, Md.

19. Aug. 11 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6th 1948, at 7-10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1933 to Aug 6th 1948 and that I last saw her alive on Aug 6th 1948

Immediate cause of death	DURATION
Terminal	
Due to: Pneumonia	2 da
Due to: Epilepsy	25 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M.D. or other

Address: Sykesville Md. Date signed: 8/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
AUG 13 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b

08253

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Yr. 9 Mos. 16 Days

Hospital, Institution, or street address where death occurred:

Maryland Tub erculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Brandywine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Joseph Henry Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 14, 1860

8. AGE:

Years	Months	Days	If less than one day
88	7	6	..... hrs. ..... min.

9. Birthplace: Prince George County (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Thoedore Jones

13. Birthplace: Maryland

MOTHER

14. Maiden name: Catherine Jenfers

15. Birthplace: Maryland

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-25-48 (month) (day) (year)

Cemetery or crematory: St. Lukes Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. August 20, 1948 (Date rec'd by registrar) Albert R. Smith Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20, 1948 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 4, 1946 to August 20, 1948 and that I last saw him alive on August 20, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W. Kuman, M.D. M. D. or other

Address: Henryton, Maryland Date signed 8-20-48

RECEIVED
AUG 26 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08260

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert M. Killmeyer

3.(b) Social Security Number 213-09-9482

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 - 1883

8. AGE: Years	Months	Days	If less than one day
65	4	28	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business General

FATHER 12. Name August Killmeyer

13. Birthplace Germany

MOTHER 14. Maiden name Alvinia Mumbaugh

15. Birthplace Maryland

16. Informant Mrs Kitty Shawberry

Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 16/48 (month) (day) (year)

Cemetery or crematory Greenmount

Location Carroll Co Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. Aug 16 1948 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1948 at 10:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948 to April 13 1948

and that I last saw h[illegible] alive on April " 1948

Immediate cause of death Coronary arteriosclerosis — DURATION 1 yr.

Due to — DURATION

Due to — DURATION

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mamie C. Parker (M. D. or other)

Address Hampstead Md Date signed 8-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 18 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08261

97

Reg. Dist. No. 74

1. PLACE OF DEATH:

County ~~XXXXXXXXXXXXXX~~ Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7-24-1940

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Downsville R.F.D. #6 ?
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ira Kline

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1870

8. AGE: Years 78 ? | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Downsville Washington md ?
(Town, county, and state)

10. Usual occupation ? Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Springfield State Hospital
Address Sykesville, Md.

17. Buried Date thereof Aug 4. 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Manor

Location Silkhmanton md

18. Funeral director Leaf Funeral Home

Address Williamsport md

19. Aug 2 1948 Harry Keer
(Date rec'd by registrar) Registror

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1948 48 at 7.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1946 to 8-1-1948 1948

and that I last saw him alive on 8-1- 1948

Immediate cause of death	DURATION
Gangrene of the r. foot	4 months
Due to General arteriosclerosis	8 years
Due to	
Other conditions Psychosis with cerebral arterio-sclerosis	8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Martin M.D. M. D. or other

Address Sykesville md Date signed 8/1/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2781
82
1948

RECEIVED
AUG 3 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 pc

08262

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years 9 months 28 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-17-M

(If outside city or town limits, write RURAL and give nearest town)

Street No. 639 N. Schroeder Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: LOUIS EDMUND LEE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Yvonne Lee

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): August 3, 1906

8. AGE: Years	Months	Days	If less than one day
42	0	15	...hrs. ...min.

9. Birthplace: Arcadia, Florida (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business:

FATHER — 12. Name: Robert Lee

13. Birthplace: Macon, Georgia

MOTHER — 14. Maiden name: Emma Jackson

15. Birthplace: Petersburg, Virginia

16. Informant: Deceased

Address:

17. Shipment (Burial, cremation, or removal. Which?) Date thereof Aug 19 1948 (month) (day) (year)

Cemetery or crematory: Mt. Laurel

Location: Philadelphia, Pa.

18. Funeral director: Robert L. Young

Address: 1216 W. Caroline St.

19. August 18, 1948 (Date rec'd by registrar) Albert R. Swankhuser Deputy - Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1948, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1940 to August 18 1948 and that I last saw him alive on August 18 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Sept. 1940
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 8/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
AUG 20 1948
BUREAU V. S.

Evidence for change of age shown on:

FILM No. G 116 AUG 13 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08263

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 19 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore- 23 (If outside city or town limits, write RURAL and give nearest town)

Street No. 512 Stockton Street (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Winifred Lee

3.(b) Social Security Number 215-12-0144

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	Separated

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 26, 1922

8. AGE: Years	Months	Days	If less than one day
25 ~~26~~	8	10	hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Domsetic

11. Industry or business

FATHER — 12. Name Jermias Scott

13. Birthplace W. Virginia

MOTHER — 14. Maiden name Rebecca Greene

15. Birthplace W. Virginia

16. Informant Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/9/48 (month) (day) (year)

Cemetery or crematory Mt Calvary Cem

Location A. A. County Md

18. Funeral director Chas. H. Carter

Address 512 Carrollton Ave.

19. August 5, 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1948 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1948 to August 5, 1948 and that I last saw her alive on August 5, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	October 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Norbert Hoffman M.D. M. D. or other

Address Henryton, Maryland Date signed 8-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 7 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

08264

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years 9 months 9 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-17-

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 640 Mosher Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nesbitt Charles Macon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Leila Macon

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): September 23, 1904

8. AGE: Years	Months	Days	If less than one day
43	11	3	..... hrs. ..... min.

9. Birthplace: Chester, South Carolina (Town, county, and state)

10. Usual occupation: Tailor and Presser

11. Industry or business:

FATHER — 12. Name: John Macon

13. Birthplace: Chester, South Carolina

MOTHER — 14. Maiden name: Julia Macklin

15. Birthplace: Chester, South Carolina

16. Informant: Deceased

Address:

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8 - 28 - 1948 (month) (day) (year)

Cemetery or crematory: Hebron, Cemetery

Location: Chester, South Carolina

18. Funeral director: Mrs Kate R Williams

Address: 922 N. Broadway St

19. August 26 1948 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1948, at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1944, to August 26 1948

aed that I last saw him alive on August 26 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1938
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Newton D. Bowman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 8/26/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 23 1948
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

08265

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Capitol

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo 17 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 mo 17 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md County: Carr

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Bernard Markell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 3d 1891

8. AGE: Years 57 | Months 7 | Days 9 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER — 12. Name: Ellis P Markell

FATHER — 13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Sarah

MOTHER — 15. Birthplace: Baltimore Md

16. Informant: Dept of Parks & Forests Address: Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 20, 1945 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Aug 20 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 12th 1945 at 345 M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from March 26 1945 to Aug 12 1945 and that I last saw him alive on Aug 12 1945

Immediate cause of death	DURATION
Due to: Coronary Thrombosis	1 hr
Due to:	
Other conditions: Epilepsy	9

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: H. H. Haslam M.D. M. D. or other

Address: Sykesville Date signed 8/13/45

RECEIVED
AUG 21 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08266

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months 8 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore -17-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1040 N. Mount Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Carrie Clara Mathews

3.(b) Social Security Number:

4. Sex: female
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Lewis Mathews
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): July 4, 1889
8. AGE: Years: 59 Months: 1 Days: 5 If less than one day: hrs. min.
9. Birthplace: Lancaster, Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Frank Carter
13. Birthplace: Lancaster, Virginia
MOTHER 14. Maiden name: Olivia Payne
15. Birthplace: Lancaster, Virginia
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/11/48 (month) (day) (year)
Cemetery or crematory: Arbutus
Location: Baltimore County
18. Funeral director: Geo. G. Kelbon
Address: 1303 Presstman. St.
19. August 9 19 48 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 19 48 at 12:01 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 19 47 to August 9 19 48 and that I last saw her alive on August 9 19 48
Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 17, 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Bruce, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 8/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 10 1948
BUREAU V. S.

08267

Evidence for change of residence shown on: FILM No. G 117 SEP 28 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL WESTMINSTER (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 YEARS

Hospital, institution, or street address where death occurred: CARROLL COUNTY HOME

How long in hospital or institution? 5 YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: Millers WESTMINSTER (RURAL) (If outside city or town limits, write RURAL and give nearest town)

Street No.: CARROLL COUNTY HOME (If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3.(a) FULL NAME: WASIL MICHALCHUK

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: ANTONINA 6.(c) If alive, give age: 7 years

7. Birth date of deceased (mo., day, yr.): JAN. 31, 1884

8. AGE: Years: 64 Months: 6 Days: 11 If less than one day: ....hrs. ....min.

9. Birthplace: OKARINA, WHITE RUSSIA (Town, county, and state)

10. Usual occupation: LABOR

11. Industry or business:

FATHER 12. Name: NOT KNOWN

13. Birthplace: " "

MOTHER 14. Maiden name: " "

15. Birthplace: " "

16. Informant: COUNTY WELFARE BOARD

Address: WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 8/13/48 (month) (day) (year)

Cemetery or crematory: COUNTY HOME CEMETERY

Location: WESTMINSTER, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 8/13 19 48 [signature] Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 11 19 48, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19 48, to 8-10 19 48 and that I last saw h... alive on 8-11-48 19....

	DURATION
Immediate cause of death: Pulmonary Edema	10 hrs
Due to: Cerebral Hemorrhage	Unknown
Due to:	
Other conditions: Active Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations: NO Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? NO (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: N. C. Hoke M. D. or other

Address: Westminster Date signed: 8-12-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

RECEIVED
AUG 16 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7X

08268

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 10-31-47

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? since 10-31-47

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1839 N. Caroline Street (If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: MULLIGAN, John Stuart

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs Rae Gertrude Mulligan 6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 12-12-88

8. AGE: Years	Months	Days	If less than one day
59	8	13	...hrs. ...min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: Retired postal clerk

11. Industry or business:

FATHER — 12. Name: John Thomas Mulligan; 13. Birthplace: Baltimore City

MOTHER — 14. Maiden name: Emma Heise; 15. Birthplace: Baltimore City

18. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/28/48 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 8/27 19 48 (Date rec'd by registrar) A.W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 19 48, at 5.00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Febr. 5 19 48, to Aug. 25 19 48 and that I last saw him alive on Aug. 25 19 48

Immediate cause of death	DURATION
Cerebral hemorrhage	12 days
Due to	
Due to	
Other conditions: Huntington's Chorea	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work?

Martin Gross, M.D.

23. SIGNATURE: Martin Gross, M.D. M. D. or other

Address: Sykesville, Md Date signed: 8-25-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B2 83a

08269

CERTIFICATE OF DEATH

Reg. Diat. No. 16

1. PLACE OF DEATH:

County Carroll County

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7-15-1941

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 7-15-41 (41)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Baltimore, Md. County Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 1732 N. Payson Avenue (If rural, give LOCATION)

2.(a) If veteran, name war No.

3.(a) FULL NAME Otto Edmund Prechtel

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16, 1881

8. AGE: Years	Months	Days	If less than one day
67	0	15	..... hrs. ..... min.

9. Birthplace U.S. (Town, county, and state)

10. Usual occupation Railroad Freight Man -Retired

11. Industry or business

FATHER
12. Name John F. Prechtel
13. Birthplace Baltimore

MOTHER
14. Maiden name Helena Wittekindt
15. Birthplace Baltimore

16. Informant Springfield State Hospital
Address Sykesville, Md.

17. Burial Date thereof 8/4/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18. Funeral director HENRY SANDER & SONS, INC.
Address NORTH AVE. & BROADWAY

19. August 4 19 48 A. W. Hedges Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1948 at 3.04 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-15-1941 19 to 8-1-48 19 48 and that I last saw him alive on 8-1-48 19 48

Immediate cause of death	DURATION
Bilateral Bronchopneumonia	
Due to Stroke and hemiplegia, left on 7-29-1948	
Due to	
Other conditions Schizophrenia, paranoid type	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. J. Masters M.D. M. D. or Other

Address Sykesville Md. Date signed 8/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08270

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4308 Spencer Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Wallace Donald Reeder

3.(b) Social Security Number: 213-18-3064

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): November 25, 1898

8. AGE: Years	Months	Days	If less than one day
49	8	10	... hrs. ... min.

9. Birthplace: Prince George's County, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: George Reeder

13. Birthplace: Prince George's County, Maryland

MOTHER — 14. Maiden name: Katie Donald

15. Birthplace: Prince George's County, Maryland

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Monday 8-9-1948 (month) (day) (year)

Cemetery or crematory New Cathedral Cemetery

Location Balt. Md.

18. Funeral director Mrs Katie R. Williams

Address 325 N. Schroeder St

19. August 4 1948 (Date rec'd by registrar) Albert R. Swankhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1948, at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1948, to August 4 1948 and that I last saw him alive on August 4 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	
Due to	May 1947
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Reuben W. Brucas M.D. M. D. or other

Address: Henryton, Maryland Date signed: 8/4/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct/age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

RECEIVED
AUG 7 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08271

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 9 mo 6 da

Hospital, institution, or street address where death occurred: Spring Field State Hospital

How long in hospital or institution? 3 yrs 9 mo 6 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 232 Park Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Rose Relleker.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 8th - 1859

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
89	7	21		

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business:

MOTHER FATHER

12. Name: George Relleker

13. Birthplace: Germany

14. Maiden name: Anna Catherine

15. Birthplace: Germany

16. Informant: Mrs J Scott Willcox

Address: 921 Bellemore Rd Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 31 1948 (month) (day) (year)

Cemetery or crematory: Baltd Lawn

Location: Baltimore

18. Funeral director: Philip Herwig Sons

Address: 2024 Orleans St

19. Aug 30 1948 (Date rec'd by registrar) C. W. Pedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 1948 at 8-30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22 1944 to Aug 28 1948 and that I last saw h[illegible] alive on July 28 1948

Immediate cause of death	DURATION
Chr. Myocarditis	6 yrs
Due to: Hypertension	
Due to: Gen'l Arterio Sclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Maston M.D. M.D. or other

Address: Sykesville Md. Date signed: 9/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08272

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Isaac Shaffer

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Gertrude Glasse Shaffer

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 18, 1876

8. AGE:

Years	Months	Days	If less than one day
71	9	21	hrs. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual occupation Retired Huckster

11. Industry or business Own grocery route

FATHER 12. Name Adam Shaffer

13. Birthplace Penna.

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Mrs. Gertrude Shaffer

Address Route #1 Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 12, 1948 (month) (day) (year)

Cemetery or crematory Baust Cemetery

Location Nr. Westminster, Maryland

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. Aug 11 48 (Date rec'd by registrar) Clay Fogle Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1948 at 11 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Arteriosclerosis	—
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Marsh Deputy Medical Examiner M. D. or other

Address Westminster Md. Date signed 8/9/48

RECEIVED
AUG 14 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08273

131a

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 yrs.

Hospital, institution, or street address where death occurred: None

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Four County Farm

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: ALICE V. SMITH

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: David W. Smith

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 7, 1864

8. AGE: Years	Months	Days	If less than one day
84 84	4	26	..... hrs. ..... min.

9. Birthplace: Urbana, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Thomas J. Day

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Leah Wolf

15. Birthplace: Maryland

16. Informant: Williard R. Smith

Address: Mt. Airy, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 5, 1948 (month) (day) (year)

Cemetery or crematory: Pine Grove Cemetery

Location: Mt. Airy, Maryland

18. Funeral director: WM Landers Funeral Home

Address: Rockville, Maryland

19. Aug 4 - 1948 Thos D Snyder

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3, 1948 19..., at 8:60 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1948, to 8/3/48 19...

and that I last saw h...er alive on 8/3/48 19...

Immediate cause of death	DURATION
Cardiac Dilitation (acute)	2 hrs
Due to: Chr. Myocarditis	? yrs
Due to: Cardio-vascular., renal desease	? yrs
Other conditions: Hemiplaegia - (right)	4 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: none ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J Stanley Grabill M. D. or other

Address: Mt. Airy, Md. Date signed: 8/3/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

08273

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 28 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 5 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. --- ---
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: SNYDER, Annie Amelia

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	~~Married~~ Widowed

6.(b) Name of husband or wife: John Snyder

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): ~~Unknown~~ Sept. 12, 1863

8. AGE: Years	Months	Days	If less than one day
84	--- 11	--- 4	--- hrs. --- min.

9. Birthplace: Maryland Baltimore County
(Town, county, and state)

10. Usual occupation: housework

11. Industry or business: ---

FATHER
12. Name: --- Wesley Nash
13. Birthplace: --- Unknown

MOTHER
14. Maiden name: --- Unknown
15. Birthplace: --- Unknown

16. Informant: Records of Springfield St. Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/19/48 (month) (day) (year)

Cemetery or ~~crematory~~: Woodlawn

Location: Pikesville, Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS INC.

Address: North &Pa. Aves. Balto. 17, Md.

19. 8-17-48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1948, at 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 1948, to August 16 1948, and that I last saw her alive on August 16 1948

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to: ---	
Due to: ---	
Other conditions: Senile psychosis	several years

(Include pregnancy within 3 months of death)

Major findings of operation: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Martin Gross M.D.
Martin Gross, M. D. M. D. or other

Address: Sykesville, Maryland Date signed: 8/16/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

U827

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Carroll

City or town Uniontown Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Leona Marie Staub

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17 1948

8. AGE: Years | Months | Days | If less than one day: 2 hrs. min.

9. Birthplace Uniontown, Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Wilmer Staub
13. Birthplace Maryland

MOTHER
14. Maiden name Leona Hines
15. Birthplace Maryland

16. Informant Wilmer Staub
Address Uniontown, Md

17. Burial Date thereof Aug 18 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Valley Cemetery

Location Pleasant Valley, Maryland

18. Funeral director D.D. Hartzler & Sons

Address Union Bridge & New Windsor, Md

19. Aug 18 1948 Margaret R. Englar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1948, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 17 (4:30 P.M.) 1948 to August 17 1948 and that I last saw him alive on Aug. 17, 1948

	DURATION
Immediate cause of death (a) Prematurity (Lived only 2 hrs)	2 hrs
Due to (b) Unknown cause	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Reese Wilkins M.D.
M. D. or other
Address Westminster Date signed 8/17/48

M C I T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG. 21 1948
BUREAU V. S.

08276

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Union Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Rural Union Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jacob Henry Stonesifer

3.(b) Social Security Number: 219-12-2437

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 19 1902

8. AGE: Years 46 | Months — | Days 9 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Hanover Condage Co.

FATHER
12. Name: John J. Stonesifer
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Ellen Jane Stonesifer
15. Birthplace: Pa.

16. Informant: John J. Stonesifer
Address: Union Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1 1948 (month) (day) (year)
Cemetery or crematory: Bixler Cemetery
Location: Bachmans Valley, Md.

18. Funeral director: H. Bankard & Son
Address: Westminster, Md.

19. Aug. 30th 1948 (Date rec'd by registrar) Calvin H. Bankard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 28 1948 at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive on Aug 28, 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: ? ?	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Julius Chepko M.D.
M. D. or other
Address: 88 W. Main Westminster Date signed: Aug 29 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 8-45-15M

RECEIVED
SEP 2 1948
BUREAU V. S.

EVIDENCE FOR CHANGE OF AGE SHOWN ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

BC 83a

08277

HM No. G 117 OCT 1 1948

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mo 27 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8 mo 27 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2551 Edmondson Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Effie Grace Tyson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: George Bond Tyson

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Mar. 30th 1879

8. AGE: Years	Months	Days	If less than one day
69 ~~68~~	4	3	..... hrs. ..... min.

9. Birthplace: md (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: at home

MOTHER FATHER

12. Name: James Cooley

13. Birthplace: Balto Co.

14. Maiden name: Clara E Armagost

15. Birthplace: md

16. Informant: George B Tyson

Address: 2551 Edmondson Avenue -- Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/48 (month) (day) (year)

Cemetery or crematory: Western Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. aug 5 1948 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3d 1948 at 6.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6th 1947 to Aug 3d 1948 and that I last saw h[illegible] alive on Aug 3d 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 wk.
Due to	
Arterio Sclerosis	8
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M.D. or other

Address: Sykesville md Date signed 8/7/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Be correct as to age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

08278

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore-1-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 828 Vine Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Robert Williams

3.(b) Social Security Number: 212-14-8692

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Lillian Williams
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): December 26, 1908

8. AGE:	Years	Months	Days	If less than one day
	39	7	17	....hrs. ....min.

9. Birthplace: Newburn, N.Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Louis Williams
13. Birthplace: N.Carolina

MOTHER
14. Maiden name: Mary Deeds
15. Birthplace: N.Carolina

16. Informant: Wife: Mrs. Lillian Williams
Address: 828 Vine Street, Baltimore-1-Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Aug 16 48 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: D.A. Co Md
18. Funeral director: Sarah L Brown Son
Address: 1084 W Monty Omery St

19. August 12 19 48 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 19 48 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 19 48 to August 12 19 48 and that I last saw him alive on August 12 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben D Kuhn M.D. M. D. or other
Address: Henryton, Maryland Date signed 8/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
AUG 14 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7

0827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: CARROLL

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 7 months, days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 years, 7 months, days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2609 W. Belvedere Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ALEXANDER WILLIAMSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 18, 1921

8. AGE: Years	Months	Days	If less than one day
27	7	3	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Roger S. Williamson
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Elsie Palmer
15. Birthplace: Baltimore, Maryland

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland

17. burial. Date thereof 8/24/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Md.

18. Funeral director: C. Vernon Lemmon

Address: 4611 Park Heights Ave.

19. 8/23/48 Roy. Hadwick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21, 1948 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1928 to August 21, 1948 and that I last saw him alive on August 21, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 months
Due to	
Due to	
Other conditions: Psychosis with mental deficiency	
Mongolian Idiot (Include pregnancy within 3 months of death)	?

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 8/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

082…

93d

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 21 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. 221 S. Stricker Street (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME ANTHONY JOHN ZIMERNACK

3. (b) Social Security Number

4. Sex: M.

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Sep.

6.(b) Name of husband or wife: Rosa McKinsey

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): June 11, 1871

8. AGE:

Years	Months	Days	If less than one day
77	2	15	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Tile setter and marble work

11. Industry or business:

FATHER

12. Name: Anthony Zimernack

13. Birthplace: Bohemia

MOTHER

14. Maiden name: Anna Pollack

15. Birthplace: Bohemia

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30-48 (month) (day) (year)

Cemetery or cremator: Holy Cross

Location: Ritchie Hgwy.

18. Funeral director: Robt. C. & Blm. Walters

Address: Pratt & E Tucker Sts.

19. 8/26 48 (Date rec'd by registrar) 19 [illegible signature] Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: Aug. 26, 19 48, at 5:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5, 19 48 to Aug. 26, 19 48 and that I last saw him alive on Aug. 25, 19 48

Immediate cause of death: Generalized arteriosclerosis

Due to: Arteriosclerotic heart disease with myocardial degeneration

Due to:

Other conditions: Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)

DURATION: ? ? ?

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. (M. D. or other)

Address: Sykesville, Maryland Date signed: 8/26/48